225 The Elderly Patient

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Just as children are not simply tiny adults, the elderly are not simply older versions of young adults. Like children, the elderly require special approaches and an understanding of the physiologic, psychosocial, and physiologic impact of aging. Evaluation of the elderly patient must focus on (1) what the patient can do, relative to what the patient should be able or wishes to do; and (2) identification of recent functional deficits that may be reversible. Since elderly persons are especially vulnerable to loss of functional capacity arising from the interaction of medical problems with adverse economic, psychologic, and social pressures, data must be collected in all these spheres.

The emphasis in providing health care to the elderly should be on maintaining functional capabilities. Most older citizens live in the community and are intellectually intact and fully independent in their daily activities. Nevertheless, many elderly persons who are not institutionalized report major activity limitations resulting from chronic conditions. These limitations include basic activities of daily living (walking, bathing, dressing, using the toilet, transferring from bed to chair, eating, going outside) and in home management activities (shopping, chores, meals, handling money).

Although a complete and precise diagnosis is essential, the functional impact of each diagnosis should also be evaluated. Specific diagnoses often have little relation to functional status, and the length of the diagnosis list provides little insight into the specific needs and capabilities of a given patient. Too often, a long list of diagnoses provides the physician with a bias that the patient is multiply impaired and frail, although this may not be the case at all. Thus, thorough evaluation of the present and likely future clinical importance of each diagnosis is essential.

Approach to Clinical Assessment

Gathering clinical data can be difficult in the elderly, compared with younger patients. Dementia, impaired hearing, and visual handicaps often limit communication. Thus, obtaining an effective history demands increased skills, time, reliance on family members or caregivers, and medical records that document the presence or absence of current symptoms. Because of the patient's decreased mobility, physical examination may be time-consuming and tedious in the frail elderly patient.

Although the standard medical history and physical examination will pick up many clinical problems that are common to all age groups, most medical specialities have developed a modified set of questions that are specific to the needs and problems of their patients. The Geriatric Review of Systems (GeriROS) presented in this chapter is a modification of the standard review of systems. It is designed to screen elderly patients for problems that might interfere with their ability to function independently. Its purpose is to identify problems that might benefit from rehabilitative interventions appropriate to the patient's age, or from services that might better support the patient and/or family in coping with disabilities common to the elderly population. It focuses on the following spheres of function:

General health status

Mental health status

Activities of daily living

Social support status

Future outlook

Family concerns

It is recommended that the student or physician use the GeriROS menu of questions at that point of the medical interview when the initial questions pertaining to the presenting problem (chief complaint) have been completed. These "scanning" questions can be used to inquire about additional symptoms, information in other areas, or additional clues that might modify the physician's understanding of the patient's presenting problems. The number of scanning questions a physician asks depends on the time available, the urgency of the patient's problems, and the physician's intuitive sense of the likelihood of obtaining any additional pertinent information.

As noted by Barrows and Tamblyn (1980), there are some advantages in using routine questions. Several times during the interview or examination, the interviewer may be confused about the patient's problem. Consequently, he (or she) may want time to think about what he has already learned, to reshape his definition of the patient's problem, or rethink his initial hypotheses about the presenting symptoms or complaints. Most clinicians feel uncomfortable about looking or thinking, yet it is difficult to walk out on the patient or stop talking. Instead, without a change in their external appearances, many clinicians switch into an inventory that they know by heart, mouthed almost automatically, only listening to the patient's answers, allowing them time to ponder the patient's problems without any detectable change in behavior. This kind of activity often causes an uninitiated observer of the physician–patient interaction to assume that clinical medicine must be an art, not a science. The logic of intermixed searching, problem-oriented searching, nonroutine questions and scanning routine questions may not be evident to the casual observer as the clinician pursues the most appropriate hypotheses in his mind.

The student or physician should not feel obligated to take the interview in a formulated sequence. Instead, he should move from one section to another as appropriate in his inquiry concerning the patient's problem. If his problem-oriented inquiry in the search section of the interview proves to be inadequate or leads down a blind alley, he may move into the scan section (e.g., GeriROS) for a time to

obtain cues or ideas. The skilled clinician moves back and forth from the search to the scan section of the interview with ease.

Once the problems have been identified, the physician may choose to make the initial intervention himself or may choose to refer the patient to a consultant (social worker, occupational therapist, physical therapist, geriatric home health nurse, geriatric evaluation clinic, etc.) or to a community agency from which additional information or services would be helpful. It should be recognized that this Geriatric Review of Systems primarily serves to screen for problems in the spheres of function and support. Many other methodologies for evaluating these problems in more detail have been developed and are extensively reviewed by Kane and Kane (1981) and Kane et al. (1984).

Rationale for Inclusion of Items in the Geriatric Review of Systems

PATIENT PROFILE

The menu of questions for the Geriatric Review of Systems is shown in Appendix A. Part I, the Patient Profile, represents data that can be extracted from the chart or obtained from the patient or family member before the patient is seen. The basic demographic and social information provide background data with which to assess the impact of chronic disease on the patient's social support network. The medical screening question easily identifies the status of the screening for treatable common problems of older persons. Inquiry into the patient's use of community services provides the physician with information about the patient's past experience with the formal support network for elderly individuals. As patients become more frail, they may require more assistance from family or community services in order to be able to continue living in their own homes in their communities. Their use of community services such as Home Health Aides, Meals on Wheels, etc., is a measure of their ability to become more *interdependent* on others without totally surrendering all elements of personal independence. It should be remembered that an important factor underlying functional impairment in the elderly is the failure of many persons to seek assistance. Studies in several countries show that symptoms of serious and treatable diseases often go unreported. Health problems reported by frail elderly persons are thus frequently only the tip of the iceberg of treatable illness. As noted by Besdine (1982), nonreporting of symptoms of underlying disease in elderly persons is an especially dangerous phenomenon when the system does not emphasize health promotion or disease prevention.

SCREENING QUESTIONS

Part II of the GeriROS presents a series of questions and maneuvers that the physician should undertake with the patient. Physicians must recognize that many diseases in the elderly have signs and symptoms that differ from those in younger adults. On the one hand, signs or symptoms of a disease that are characteristic for middle age may be replaced by other signs or symptoms in older persons. Syncope or congestive failure, rather than acute chest pain, may be harbingers of myocardial infarction. On the other hand, the older person may present with nonspecific signs or symptoms such as confusion, weakness, falls, weight loss, or withdrawal. Nevertheless, the screening questions in this section may also help clarify a puzzling set of presenting signs and symptoms in some older persons. Asking the elderly person to describe his or her general state of health provides a quick and reliable gross assessment of the general health status of the older person. The patient's description of perceived health problems and treatment regimens provides some assessment of the patient's understanding of chronic illness and may provide some early clues as to disruptions in memory or affect. This is particularly important when asking the patient to list his or her medications and their purposes. The physician can ascertain whether the patient understands the need for the drugs, the patient's compliance with instructions, whether the medications are being used but not prescribed. Often this set of questions will reveal that the patient may be taking medications from multiple sources (each unknown to the other) that may be producing signs or symptoms because of adverse drug–drug interactions.

Inquiry about abnormalities of vision, hearing, teeth, balance, gait, and recent life changes are frequently overlooked in the elderly, yet may carry an important functional significance. Presbyopia and other visual handicaps occur in approximately 15% of patients. Presbyopia is easily correctable with lenses, with subsequent major impact on the level of the patient's functional independence. Presbycusis is another common problem of the older person (22%) and is frequently amenable to hearing-aid treatment. Its presence may predispose a patient to depression or paranoia. By asking the patient to look up a telephone number in the telephone directory and dial that number on the telephone, the physician may be able to check the patient's capabilities for following complex directions using an important "community survival instrument." Evaluation of the patient's teeth is important for helping the patient maintain adequate and balanced nutrition, as well as pleasing cosmetic appearance. Unless the patient has grossly infected gums and mouth, the patient may be a candidate for dentures. According to Hogue (1982), "people who fall, fall again." Falls can be indicative of poor visuoperceptual coordination and/or the presence of obstacles (slippery rugs, poor lighting of stairs, unnecessary furniture) in the patient's living environment. Less frequently, they may be harbingers of seizure disorders or cardiac arrhythmias. Finally, inquiry into recent life changes may provide valuable clues about the health of the patient. Changes involve loss, and multiple losses often predispose to physical illness as well as depression. A change need not be negative in order to produce stress.

MENTAL STATUS

Inquiry into the mental health status of the elderly patient is most important in view of the high incidence of dementia and depression among the elderly. If this examination provides any suggestion of functional cognitive impairment, it is wise for the physician to verify the accuracy of other aspects of medical history with relatives and friends of the patient. By asking the patient to describe a typical day, we can frequently learn important information about the patient's interests, social activities, and eating habits. However, it is important to delve into other aspects of cognitive functions in a more formal manner. Among the early signs of dementia in older individuals is the gradual loss of memory and the progression of the impairment of judgment, calculation ability, and reasoning. Only later in the course of the disease does disorientation become a major phenomenon. Like the younger patient, changes in mood and blunted affect are typical of depression. A variety of mental status

examinations have been developed for use with the elderly. The FROMAJE Mental Status Examination, developed by Libow (1981), is a rapidly administered, easily remembered mental status evaluation with which the general physician can quantify the mental status of his patient.

ACTIVITIES OF DAILY LIVING

As noted, the need for assistance in the activities of daily living are an excellent marker of the patient's level of independence and interdependence and may provide clues to other underlying disorders. If the patient has any difficulties getting around in his community, there is some question to the patient's ability to function independently. Any deficits, real or perceived, point to the need for more in-depth evaluation and/or a close look at the patient's support network. Patients who experience difficulties in dressing or undressing may have difficulties with degenerative joint disease or neurologic dysfunctions such as dementia, parkinsonism, or other mixed neuromuscular disorders. Patients who experience difficulties in fixing meals may have dexterity problems, which is a significant marker for the patient's ability for functional independence. They also may suggest some judgment deficits. In patients who have difficulty in getting to the bathroom or out of bed unassisted, it is important to screen for incontinence or remediable mobility problems so that appropriate equipment can be provided. Patients who have difficulties handling their finances are at significant risk for surviving independently in the community. They need to be screened for potential dementia and the need for additional support persons in their lives.

SOCIAL SUPPORT AND OUTLOOK

In evaluating the social support system of the patient, it is important to construct a genogram that outlines the family constellation and identifies important support people, family-related diseases, and family influences on chronic illness and disease. It is important to ascertain who the patient considers his or her most important confidante or support person. The absence of any important confidante may be an important marker for mental illness. If there is an inadequate support network, there is an increased likelihood for the need for institutionalization of the patient if he or she is otherwise physiologically frail.

The patient's future outlook provides an index of general satisfaction with life. A strong desire for ending life may be a tip-off to depression. When the patient shows difficulty in anticipating future problems or worries, we may have a clue about the patient's ability to abstract realistically. When the impairment is minimal, this may indicate need for anticipatory guidance.

Separate questioning of the family or the patient's friends and/or caregivers provides additional useful information. Family members provide 80% of the long-term care of elderly individuals in the United States. They are frequently sources of validation of the patient's information and may guide the physician to areas of concern not identified in other ways.

Conclusion

The ultimate goal in the care of elderly individuals is providing health care that maintains maximum functional capability. This requires helping the patient and his or her family to use personal and community resources optimally to cope with the problems that they encounter. The normal physiologic changes of aging, as well as the toll of various diseases, will ultimately reduce the functional reserve of older persons compromising their responses to environmental stresses. Nevertheless, a thorough knowledge of age-related physiologic and psychologic changes, coupled with attempts to detect and remedy amenable problems at an early stage, will maximize the opportunities for our older citizens to maintain their functional independence. The Geriatric Review of Systems provides a tool for attaining that goal.

Geriatric Review of Systems (GeriROS)

Part I. Patient Profile

These data are to be abstracted from the chart and/or obtained from the patient or family member before the patient is seen.

Fill in or circle information where appropriate:

Next of kin:
Marital status: M S W D Sep

Educational level: 1–8 HS College
Occupational status:

Working Current job:
Previous jobs:
Unemployed
Retired: (N/Y)
Volunteer:

Type of housing
Farm
House
Apartment
Other:
Alone
With spouse
With family
Other:
One story
Two stories
Ground floor

Place of birth (city and state):
Place person has lived most of his or her life (city and state):
How does person get to doctor's office (type of transport and who transports):

Diagnoses:

Date of last screening tests
Glaucoma:
Blood chemistries:
HCT:
Hemoccults:

Checklist:

Use of community services	Now	Past	Comments
1. Home health services/professionals			
2. Home health services/aides-helps			
3. DSS			
4. Transportation for the elderly			
5. Nutrition sites			
6. Adult day care			
7. A.A. or AlAnon			
8. Other clinics or doctors			
9. Senior center			
10. Meals on Wheels			
11. Council on Aging services			
12. Other:			

Part II. Physician Screening Questions and Maneuvers

Section I. General health status

A. How would you describe your health?
B. Describe the health problems you are having now:
   Problems How is it being managed?
   1. Tell me all of the medications you are taking and what they are for.
      Medications Purpose
   2. How is your vision? (Demonstrate by using phone book to find number and dial.)
   3. How is your hearing? (Validate by asking declarative questions with varying volume, pitch, and paces.)
   4. Are you having problems with your teeth? (Note any problems observed in course of interview.)
   5. Have you fallen in the last year? (Patient may need prompting to get this information. Use descriptors like "tripped," "fell out." If yes, describe when, how often, and circumstances.)
C. What changes/events have taken place in your life in the last year? (Patient may need prompting—ask for good events and bad ones, such as deaths of relatives, neighbors, changes in living conditions, jobs, retirement, revision of personal habits, change in church or social activities.)
   Change/event Date

Section II. Mental health status

"I'm going to ask you a set of questions now, some of which may seem quite easy or trivial, some of which you may have difficulty with. Please answer them as best you can."

A. Describe a typical day for you: (Try to get a feel for level of activity, interests, sleep/rest, level of social activity, eating habits.)
B. Administer mental status test (FROMAJE*)

Function

1 = Mental function is adequate so that no at-home support is necessary.
2 = Because of mental impairment, patient will need some at-home support at least part of the day or week (from family, friends, visiting nurse service, etc.).
3 = Because of mental impairment, patient needs 24-hour at-home support and supervision, 7 days a week.

*Libow L. A rapidly administered, easily remembered mental status evaluation: FROMAJE. In: Libow L, Sherman F, eds. The core of geriatric medicine. St. Louis: CV Mosby, 1981;85–91.

Reasoning

Proverbs (for example: "The early bird catches the worm" and "A stitch in time saves nine.")
1 = Patient explained proverb well; gave general connotations of proverb.
2 = Patient gave some semblance of meaning, but with some incompleteness or was unable to generalize.
3 = Patient was completely unable to ascribe any meaning or gave a totally incorrect explanation.

Orientation

Ask for: Day of the week (if necessary, present choices) Month, date, and year
Where are you now? (Is this your apartment/house? A hotel? A doctor's office, hospital, nursing home?)
What is your name?
1 = Patient was generally accurate and made only minor errors in time, place, or self.
2 = Patient made a significant error in one area of time, place, or self.
3 = Patient made significant errors in two or three areas of time, place, or self.

Memory

Distant: Who was the president of the United States during World War II and was in a wheelchair?
What U.S. president was assassinated in the early 1960s?
Where were you born? In what year were you born?
Recent: What did you have for breakfast today?
Where were you at this time yesterday?
Immediate: What did I ask you about the U.S. presidents?
Remember the numbers 4, 12, and 18. I will be asking you to repeat them in the next few minutes. (Then ask to repeat.)

1 = Patient was generally accurate and made only minor errors in distant, recent, or immediate memory.
2 = Patient made a significant error in one area of distant, recent, or immediate memory.
3 = Patient made a significant error in 2 or 3 areas of distant, recent, or immediate memory.

Arithmetic

Count back from 100 to 90
Subtract sevens from 100
Count from 1 to 20

1 = Patient was generally accurate and made only minor errors.
2 = Patient made only one significant error.
3 = Patient made two or more significant errors.

Judgment

At night if you need some help, how can you obtain it?
If you are having trouble with a neighbor, what can you do to improve the situation?
If you see smoke in the wastepaper basket, what should you do?

1 = Patient gave a generally sensible response.
2 = Patient demonstrated some poor judgment.
3 = Patient demonstrated extremely poor judgment.

Emotional state

(Observe during the interview; ask about crying, sadness, depression, optimism, etc. Consider behavior according to life situation.)

1 = Patient's emotional state seemed reasonable and appropriate.
2 = Patient showed extensive or inappropriate depression or grandiosity.
3 = Patient showed extremely unreal or inappropriate ideas (delusional or hallucinatory, extreme depression or suicidal ideation).

Overall FROMAJE *rating*

7–8 = No significant abnormality in behavior or mentation
9–10 = Mild dementia or depression
11–12 = Moderate dementia or depression
13+ = Severe dementia or depression

Section III. Activities of daily living status

A. Are you having any difficulty getting around your home or the community?
   1. Problems getting out of bed in the morning?
   2. Problems shopping for food (handling money, walking, carrying groceries, etc.)?
   3. Problems getting to appointments?
   4. Demonstrate: (Note any abnormalities, equipment, or appliances.)
      a. Getting up out of a chair (e.g., from waiting room)
      b. Walking across the room (e.g., from waiting room)
      c. Walking up steps (e.g., onto examination table)

B. Are you having any problems dressing or undressing? (Observe some part of the process, especially lower extremity activities such as putting on stockings or pants.)

C. Are you having any problems fixing meals or eating?
   1. At home
   2. Demonstrate: make a cup of tea or coffee (have props ready). (Use this maneuver only if the patient is unable to perform the telephone book maneuver in I.B.2 or if you want the information for other reasons.)

D. Do you ever have difficulty using toilets or tubs/showers (equipment, access, mobility, continence, fear of falling, "false alarms")?
   1. At home?
   2. In the hospital?

E. Do you receive any help handling your finances? Who does that?

Section IV. Social support status

A. When times are hard or difficult, who do you depend on to help you/who do you turn to for help? (Inquire about age and fitness of person identified.)

B. Who would you depend on to care for you if you got sick/became ill? (Inquire about age and fitness of person identified.)

Section V. Future outlook

A. Do you anticipate or worry about any future problems, health or otherwise, that we might help you with now? What problems do you anticipate?

B. In general, would you change any part of your life, past or present, if you could? What would you change?

Section VI. Family concerns

A. Do you have any concerns about your relatives?

B. What are your concerns?

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